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DSL-BQA-00-035

To: Hospitals

HOSP 16

From: Otis Woods, Section Chief
Health Services Section

via: Susan Schroeder, Director
Bureau of Quality Assurance

**Hospital Report to HCFA
Patient Death in Seclusion or Restraint**

The hospital Condition of Participation: Patients' Rights that became effective for all hospitals participating in the Medicare program on August 2, 1999, contained, at 42 CFR 482.13(f)(7), the following requirement applicable to patients restrained or secluded for behavioral management:

The hospital must report to HCFA any death that occurs while a patient is restrained or in seclusion, or where it is reasonable to assume that a patient's death is a result of restraint or seclusion.

HCFA has directed the Bureau of Quality Assurance (BQA) to notify Wisconsin hospitals that they must report to the HCFA Regional Office any death that occurs while a patient is restrained or in seclusion for management of behavior, or where it is reasonable to assume that a patient's death is a result of restraint or seclusion used to manage behavior. There are no death reporting requirements for restraints used in acute medical and surgical care. Behavior management is not limited to patients with psychiatric or developmental disabilities diagnoses; the HCFA definitions are based on the purpose of the restraint, not on the diagnosis of the patient.

The HCFA definition of restraint and of seclusion found at 42 CFR 482.13(f)(1) is:

The patient has the right to be free from seclusion and restraints, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. The term "restraint" includes either a physical restraint or a drug that is being used as a restraint. A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body. A drug used as a restraint is a medication used to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition. Seclusion is the involuntary confinement of a person in a room or an area where the person is physically prevented from leaving.

The HCFA mandated report is in addition to the report required by state statutes, s. 50.04(2t) and s. 51.64. State statutes require hospitals to report to the Bureau of Quality Assurance (BQA) within 24 hours when there is reasonable cause to believe a patient death may have been due to physical restraints/seclusion, psychotropic medications, or suicide in a psychiatric hospital or in a psychiatric unit of a hospital.

HCFA has directed BQA to conduct an investigation of deaths that occur while a patient is restrained or in seclusion, or where it is reasonable to assume that a patient's death is a result of restraint or seclusion, within 5 business days. The information that HCFA will be collecting from hospitals includes:

Contact Information: Facility contact and facility contact's phone number.

Provider Information: Hospital name, Medicare provider number, address and zip code.

Patient Information: Name, date of birth, Medicare/Medicaid number, admitting diagnoses, date of admission, date/time of death, cause of death, length of time in restraints/seclusion, circumstances surrounding the death, whether or not a root cause analysis has been conducted, results of any facility investigation.

Restraint/Seclusion Information: Type (physical restraint/seclusion/drug used as restraint); restraint method; reason(s) for seclusion/restraint use; less restrictive methods of behavior management considered; restraint/seclusion order date/time; quote of actual restraint/seclusion order; monitoring method(s), frequency, last date/time monitored; last date/time of assessment; other instances of restraint/seclusion deaths since 8/2/99; if prior deaths, were steps taken with previous deaths to prevent reoccurrence?

Hospitals should be prepared to supply the above details either by telephone to the HCFA contact person, Dorsey LeCompte, at the time of the initial report, or to the BQA surveyor onsite.

Dorsey LeCompte's telephone number is (312) 353-5183, and her e-mail address is:

DLecompte@hcfa.gov

Questions regarding this memo may be directed to BQA:

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